

**United States Environmental Protection Agency  
Criminal Investigation Division  
Investigative Activity Report**

**Case Number**

0606-0015

**Case Title:**

CES Environmental Services

**Reporting Office:**

Houston, TX Resident Office

**Subject of Report:**

Interview of OSHA Investigator (b) (6), (b) (7)

**Activity Date:**

March 17, 2009

**Copies to:**

**Related Files:**

**Reporting Official and Date:**

(b) (6), (b) (7)(C), SA

27-MAR-2009, Signed by: (b) (6)(b) SA

**Approving Official and Date:**

(b) (6), (b) (7)(C), SAC

01-APR-2009, Approved by: (b) (6), (b) (7), SAC

**SYNOPSIS**

03/17/2009 - On 03/17/2009 SA (b) (6), met with Occupational Safety and Health Administration (OSHA) Area Office Investigator (b) (6), (b) (7) located at 17625 El Camino Real, Suite 400, Houston, TX 77058. (b) (6), provided information about CES Port Arthur.

**DETAILS**

On 03/17/2009 SA (b) (6), met with Occupational Safety and Health Administration (OSHA) Area Office Investigator (b) (6), (b) (7) located at 17625 El Camino Real, Suite 400, Houston, TX 77058. (b) (6), provided information about CES Port Arthur. Those present were EPA CID SA (b) (6), (b) (7)(C) OSHA Investigator (b) (6), (b) (7)(C) OSHA Assistant Area Director (b) (6), (b) (7)(C) and OSHA Compliance Safety and Health Officer (b) (6), (b) (6), (b) (7)(C).

(b) (6), had been investigating a fatality at CES Environmental Services (CES) Port Author facility. (b) (6), said that the fatality investigation report was not finalized at this time but would provide EPA CID a copy after completion and approval.

(b) (6), said that Joey Sutter died at CES Environmental located at 2420 South Gulfway in Port Author, Texas. OSHA believes there were two known witnesses to the fatality. One witness (b) (6), (b) (7)(C) was contacted and gave a statement to OSHA. The other witness, (b) (6), (b) (7)(C) did not give a statement to OSHA and has been very difficult for OSHA to locate.

(b) (6), said that called (b) (6), (b) (7)(C) by telephone to setup an interview. The interview was set up for January 6, 2009 at a Port Author Starbucks. (b) (6), said (b) (6) assumed it was (b) (6) day off. During the phone call (b) (6) continually asked (b) (6), if Joey Sutter had died of chemical exposure. (b) (6), advised that the medical examiner investigation was not complete at this time.

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(b) (6), went to CES Port Author to retrieve samples from CES Employee, (b) (6), (b) (6), (b) (6) asked (b) (6), if (b) (6) was the OSHA Investigator that (b) (6) was meeting with later. When (b) (6), stated (b) (6) was not prepared for such a question but answered to (b) (6), (b) (6) that (b) (6) was meeting with (b) (6) later. (b) (6), (b) (6) told (b) (6) that (b) (6) wanted to talk to (b) (6) at CES Port Author. (b) (6), spoke with (b) (6) and agreed to meet later at a McDonald instead of neither the previous agreed Starbucks nor the CES Port Author facility that (b) (6), (b) (6) was insisting on.

At the McDonalds (b) (6) again asked repeatedly if Sutter died from chemical exposure. (b) (6), told (b) (6) the medical examiner had not ruled on cause of death at this time. (b) (6) told (b) (6), that the day of the fatality (b) (6) and Joey Sutter were tasked with taking a sample from tank number 267. (b) (6) described tank number 267 as a very shiny metal 18 wheeler tanker trailer without the tractor cab attached. There is a ladder attached to the side of the tanker leading up to a dome access lid.

(b) (6) stated that (b) (6) went up the ladder first and stood on top of the tanker while Sutter climbed the ladder and then stood with (b) (6) feet on the ladder while proceeding to conduct the sample. (b) (6) said that Sutter only opened a valve on the tank to release pressure and loosened a wing nut on the hatch but did not open the dome lid to the tank. (b) (6) said that Sutter then bled through the nose and passed out. (b) (6) stated that (b) (6) held on to Sutter until (b) (6), (b) (7)(C) called 911 and came up the ladder to perform CPR.

The other witness, (b) (6), (b) (7)(C) has not returned phone calls and made contact with OSHA for an interview. OSHA learned from other employees that (b) (6), (b) (6) version of the fatality noted the tank lid being opened. (b) (6), (b) (6) is no longer employed by CES.

(b) (6), said that the report of the fatality on their hotline was reported by (b) (6), (b) (7) at 6:04pm on 12/18/2008 as a possible aneurism. (b) (6), had asked (b) (6), where (b) (6) had heard anything about an aneurism. (b) (6), said that (b) (6) heard about an aneurism from the EMS or Fire Department. (b) (6), has been unable to locate any EMS or Fire Department personnel that responded and handled the fatality as anything other than a hazardous materials incident.

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